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In The

Supreme Court of the United States

October Term, 1985

MARGARET M. HECKLER, SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Petitioners

v.

MICHIGAN ACADEMY OF FAMILY PHYSICIANS, ET AL.
Respondents

BRIEF IN OPPOSITION TO THE PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

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QUESTIONS PRESENTED

Did the Court of Appeals correctly conclude that 42 U.S.C. Sec. 1395ff and 42 U.S.C. Sec. 405(h) do not deprive Respondents of a judicial forum for redress of their substantial statutory and constitutional claims?

If it is determined that 42 U.S.C. Sec. 1395ff and 42 U.S.C. Sec. 405(h) do authorize an agency of the federal government to violate the Medicare statute or the Fifth Amendment to the United States Constitution with no forum for those affected to take redress, does such lack of forum violate the United States Constitution?

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STATEMENT

1. Background

This case involves a challenge to a regulation promulgated by the Department of Health and Human Services which permitted differential treatment to certain allopathic (M.D.) family physicians (and their patients) versus all other allopathic physicians (and their patients) under the Medicare Program. The differential treatment invalidated by both the trial court and the Court of Appeals is implemented through the creation and maintenance of separate fee screens which place family physicians in the same fee screen as podiatrists, chiropractors, and dentists while physicians with different specialties were placed in a separate specialty fee screen. Respondents alleged in their complaint that the differential treatment of family physicians compared to all other types of physicians violated both substantive due process under the Fifth Amendment to the United States Constitution and the Medicare statute, specifically 42 U.S.C. 1395a (which guarantees a free choice of physicians by patients) and 42 U.S.C. Sec. 1395u(b)(3) (which requires that prevailing fee limitations be based upon similar services). No monetary relief was requested, Respondents requesting a finding that the maintenance of separate fee screens by Petitioner in administering the Medicare Program violated the Medicare statute and the Fifth Amendment. As discussed, infra, it is essentially the position of the Petitioners that Respondents have no forum whatsoever to address their statutory and constitutional claims.

2. The Medicare Act

Petitioners' description of the Medicare Program is sufficient and will not be repeated here in detail, except for those provisions that relate directly to the present case or those provisions not discussed by Petitioners. Under Part B of the Medicare Program the Secretary is authorized to enter into contracts with private insurance companies for its administration. 42 U.S.C. 1395u. Part B of the Medicare Program concerns services provided by physicians,

podiatrists, chiropractors, and dentists. In contrast, Part A of the Medicare Program provides coverage for institutional care. The distinction between Parts A and B of Medicare are relevant to the present appeal to the extent that it serves as a point of contrast for both past precedents and the review mechanisms provided under each Part.

Under Part A, determinations of both "entitlement to benefits" and "amount of benefits" are made by the Secretary, 42 U.S.C. Sec. 1395ff(a). Under Part B the determination of "entitlement to benefits" is made by the Secretary. Under Part A, an individual dissatisfied with either an eligibility or amount of benefits determination is entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision pursuant to 42 U.S.C. 405(g). In contrast, 42 U.S.C. Section 1395ff(b) provides for a hearing by the Secretary and judicial review of the Secretary's final decision only where an individual is dissatisfied with entitlement determinations under Part B.

The hearing rights of individuals dissatisfied with an "amount of benefits" determination under Part B consist of a hearing before a carrier selected by the agency to administer the Medicare Program, here Blue Cross and Blue Shield of Michigan. Specifically, Sec. 1395u(b)(3)(C) provides that an individual will be granted an opportunity for a "fair hearing by the carrier" in cases of controversy over $100.00 with regard to services furnished or not acted upon with reasonable promptness.[1] Section 405(h) generally indicates that the findings of the Secretary following a hearing are binding and no further review (judicial or otherwise) is per-

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[1] This statute states as follows:

> (3) Each such contract shall provide that the carrier—
>
> (C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case, where the amount in controversy is $100 or more, when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy.

missible unless otherwise provided. Under the general provisions of the Social Security Act, a hearing by the Secretary (and judicial review thereafter) is accorded by 42 U.S.C. Sec. 405(g). However, 42 U.S.C. Sec. 1395ii fails to make Sec. 405(g) applicable to the Medicare Act.

Petitioners have gone to great lengths in their Petition for Writ of Certiorari to characterize Respondent's cause of action as a "claim for benefits." The assertion that Plaintiff's cause of action is an "amount of benefit case", however, is repudiated by Petitioners' own regulations. The fair hearing conducted by the carrier is controlled by regulations promulgated by the Secretary and certain provisions of the "Carrier's Manual."[2] The types of challenges that may be heard by the carrier are carefully delineated by regulation, 42 CFR 405.801. The regulations provide for a hearing when a party is dissatisfied with a determination denying a request for payment, the amount of payment or where the request for payment is not being acted upon with reasonable promptness. A party is then given a right to a "fair hearing" (42 CFR 405.820) conducted by a hearing officer designated by the carrier. (42 CFR 405.823). The jurisdiction of the hearing officer is carefully circumscribed by regulations as follows:

> The hearing officer in exercising the authority to conduct a hearing on this Section 1842(b)(3)(c) of the Act is to comply with all the provisions of Title XVIII of the Act and regulations issued thereunder, as well as with policy statements, instructions and other guides issued by the Health Care Financing Administration in accordance with the Secretary's agreement with the carrier. 42 CFR 405.860.

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[2] The Carrier's Manual was compiled by the Health Care Financing Administration. Its declared purpose is to serve as "practical operation instructions needed by the contractors responsible for the administration of the supplementary and medical insurance program — Part B Medicare." (forward to Carrier's Manual).

The restrictions imposed upon the hearing officer's jurisdiction are made even more explicit by the Carrier's Manual, the compilation of guidelines a hearing officer is required by the above regulation to follow. Section 12016 of the Manual states:

> Authority — The HO occupies a significant position in the administrative appeals process affording dissatisfied individuals with hearing rights as provided in Section 1842 (b)(3)(C) of the Act. Authority of the HO is limited to the extent that he must comply with all provisions of Title XVIII of the Act and regulations issued thereunder, as well as with HCFA rulings, general instructions, and other guides issued by HCFA with the Medicare Bureau. *The HO does not have the prerogative of overruling the provisions of the law or of interpreting them in a way different than that of the Medicare Bureau when he is in disagreement with their intent; nor may he use hearing decisions as a vehicle for commenting upon the legality, constitutional or otherwise, of any provision of the Act or regulations relevant to the Medicare Program.* (emphasis added)

3. Proceedings

Respondents commenced this action on October 8, 1976 alleging that the differential treatment of family physicians, compared to all other types of physicians in the State of Michigan, violated both substantive due process under the Fifth Amendment to the United States Constitution and the Medicare Statute. No monetary relief was requested, Plaintiffs seeking prospective relief in the form of an injunction prohibiting Petitioners from treating family physicians differently from other physicians and a finding that the maintenance of separate fee screens by Petitioners violated the Medicare statute and the Fifth Amendment. Respondents requested that the court enjoin Petitioners from treating family physicians differently from other physicians for purposes of the Medicare Program.

Respondents' statutory claim based upon 42 USC Sec. 1395u(b)(3)[3] asserted that, contrary to the Medicare Act's mandate that "similar service" be the basis for determining reasonable charges, the Secretary had promulgated a regulation which authorized the carrier to segregate and group physicians on the basis of specialty practice for the purpose of developing reimbursement screens used for all types of procedures, including primary care procedures, thereby according different payment for similar service. See 42 CFR 405.504(b)[4]

Prior to suit, in October, 1974, Respondents requested a hearing with the Carrier to provide the individual Respondents with an opportunity to demonstrate that Respondent-physician's training and experience were such as to warrant

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[3] 42 USC Sec. 1395u(b)(3) states as follows:

"In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physicians or other person furnishing such service, as well as the prevailing charge in the locality for similar services. No charge may be determined to be reasonable in the case of bills submitted or request for payment made under this Part after December 31, 1980, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) a prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover seventy-five (75%) percent of the customary charges made for similar services in the same locality during the last preceding calendar year . . ."

[4] This regulation provides:

"The range of prevailing charges in a locality may be different for physicians or other persons who engage in a specialty practice or service than for others. Existing differentials and the level of charges between different kinds of practice or service could, in some localities, lead to development of more than one range of prevailing charges for application by the carrier in its determination of reasonable charges. Carrier decisions in this respect shall be responsible to the existing patterns of charges by physicians and other persons who render covered services and should establish differentials in the level of charges between different kinds of practice or service only where in accord with such patterns."

equal payment for primary care procedures. In December, 1974, the Carrier responded to the request indicating that Respondents could utilize a peer review procedure. In March, 1975, the Carrier further clarified the scope of the hearing by indicating that an adjudication as to the reasonableness of the specialty differential could not be involved and the Carrier would accept no adjudication which eliminated such a differential. Additionally, Respondent-patient, without counsel, protested the prevailing fee determination as to services performed by her treating physician and was notified by the Carrier that she was without recourse and nothing could be done.

Prior to trial, the Secretary moved to dismiss Respondents' Complaint for lack of jurisdiction as to the statutory claim and as to the constitutional claim on the basis that the constitutional claim was insubstantial. In December, 1977, the Secretary's motion was denied by the Honorable James Churchill in a memorandum opinion which noted:

> I am influenced by the improbability that Congress would intentionally authorize an administrative agency to delegate to a private contractor the power to violate the Constitution of the United States in the name of the United States without recourse.

Following trial on the merits, the district court held that the Carrier had not developed a procedure to determine what types of professional services were similar and that the classification scheme of 42 CFR 405.504(b) was plainly inconsistent with the Medicare statute which "mandates the customary charges of physicians for similar services to be the test for reimbursement." 502 F. Supp. at 755.

The district court further found that this classification scheme violated yet another provision of the Medicare statute, 42 USC Sec. 1395a, because it tended to influence a beneficiary's choice of physician and reduced that benefici-

ary's reimbursement solely by virtue of the choice of the type of physician to perform a particular medical service.[5]

Since the district court found the Secretary's and Carrier's actions to be a clear violation of the Medicare Act, it did not consider the constitutional arguments advanced by Respondent, but did state that "such segregation is not rationally related to a legitimate purpose of the Medicare statute." 502 F. Supp. at 755.

By way of remedy, the district court issued a mandatory injunction directing the Petitioners to provide a single screen for all physicians separate from a screen for chiropractors, podiatrists and dentists.

The court of appeals affirmed the decision of the district court, both in terms of subject matter jurisdiction and the substantive merits of the lawsuit. However, the court determined that the remedy adopted by the district court went too far. The court of appeals remanded the case to the Secretary for reconsideration of the reimbursement plan with the proper focus of "similar service."

As to jurisdiction, the Court of Appeals recognized that this Court's decision in *United States* v *Erika*, 456 U.S. 201 (1982), held that Congress clearly and convincingly intended no judicial review of amount of benefit cases. However, after a review of the applicable statutes and case law, the court concluded that jurisdiction did exist under the particular circumstances of this case.

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[5] The district court demonstrated the financial impact of this classification scheme by focusing on the effect upon respondent-patient. Respondent-patient was a Medicare recipient whose treating physician was a family physician who had been in practice for twenty-three (23) years. While being on staff at three different hospitals and while being an instructor at Michigan State University, this physician was neither board eligible nor board certified by the American Board of Family Practice. The district court noted that solely as a result of selecting this physician (a choice protected pursuant to 42 USC Sec. 1395a) respondent-patient was in fact paying more for her physician visits and treatments although paying the same premium as another recipient who may have chosen a physician defined by the Petitioner as a "specialist."

As to the merits of Respondents' case, the Court of Appeals found that the "touchstone" of 42 USC 1395u(b)(3) is "similar service" and that there was an obvious inconsistency between this statute and the disputed regulation. The Court of Appeals found the regulation "irrational" and "invalid." 728 F.2d at 329. Because the regulation was statutorily unsound, the court did not address the constitutional issues raised in the case. 728 F. 2d at n. 5. See *Hagans* v *Levine*, 415 U.S. 534 (1974).

Following a remand on a petition for rehearing, the U. S. Court of Appeals for the Sixth Circuit reaffirmed its position on jurisdiction on March 19, 1985. Contrary to statements contained in the Petition for Writ of Certiorari, however, the U. S. Court of Appeals in neither of its decisions ignored the precedent of this Court. The fact is the initial opinion cited and analyzed in detail *United States* v *Erika, supra*, and the subsequent opinion, went into great depth as to the application of *Ringer, supra*, and noted that in *Ringer, supra*, claimants had not exhausted the administrative remedy afforded by Sec. 405(g). The court further noted that no 405(g) administrative review was available to Respondents in this case, and that the Supreme Court has itself exercised federal jurisdiction to hear constitutional challenge to the administrative review process provided by the Social Security Act. *Schweiker* v *McClure*, 456 U.S. 188 (1982). In holding for Respondents, the court indicated that the arguments of the Secretary were not unpersuasive, but the U. S. Court of Appeals was inclined to follow the time honored view that a right cannot exist in a vacuum and that for every right there must be a remedy.

The suggestion of the Petitioners that the decision of the U. S. Court of Appeals threatens to reintroduce the regime of uncertainty and widespread litigation on Part B issues that prevailed prior to *Erika* ignores the Sixth Circuit's decision in *Herzog* v *Secretary*, 682 F2d 121 (6th Cir, 1982), a case noted and distinguished by the Sixth Circuit. In *Herzog*, the claimants disputed the fact that chelation therapy was held by the Secretary to be non-reimbursable.

The claimants sought and were afforded an administrative review of this adverse decision. They subsequently filed suit in federal court. The Court of Appeals, relying extensively on this Court's opinion in *Erika* ruled that federal court jurisdiction did not exist to hear the claimants' amount of benefit case.

Contrary to the assertion of Petitioners, the Sixth Circuit's decision in this case is limited to statutory and constitutional claims for which there is no administrative forum available.

This is the Petitioners' second Petition for Writ of Certiorari involving this case. In both cases, Petitioners have declined to seek review of the Court of Appeals decision on the merits. Nevertheless, in the body of Petitioners' arguments they see fit to address the merits of the case on a limited basis. For example, in footnote 2 of the Petition it is stated that the government acknowledged in proceedings in the district court that board eligible family physicians should have been included in the specialist category. In fact, while the government did concede at trial that it had no basis to treat board eligible family physicians as non-specialists, the government refused an invitation of the court to place such physicians in the specialty screen. See Appendix A. Furthermore, the government repeatedly characterizes 42 USC 1395u(b)(3) as a requirement that the Carrier "take into consideration" similar services in determining payment ceilings. Without so stating, the government appears to imply that the Carrier has the option of taking similar services into consideration, but may decline to follow similarity as its test. This inference ignores the balance of the statutory provision noted in footnote 3 of this Brief, which states in no uncertain terms that no charge may be determined to be reasonable which exceeds the 75th percentile of charges for similar services.

In essence, by relying only on the jurisdictional issues and ignoring the merits of this case, the government is seeking a determination that Respondents have no recourse to

address statutory and constitutional violations. Respondents, prevailed on a statutory claim in both the district court and the circuit court, and the government conceded that it had no rationale for its actions, at least as it pertained to a portion of Respondents' claim.

In its petition, the government has also glossed over the fact Respondents have raised a serious constitutional claim which the Honorable James Churchill found had sufficient merit to withstand a motion for summary judgment, and which the Honorable Horace Gilmore declined to rule upon, having found the statutory violation but characterized the Petitioners' position as not related to any legitimate purpose in the Medicare statute and defying all reason. 502 F Supp at 755. Furthermore, the U. S. Court of Appeals, in both of its opinions, recognized Respondents' constitutional claims, noting that since it had found the regulations statutorily unsound, the constitutional issues need not be addressed. Nowhere in Petitioners' Petition for Writ of Certiorari are Respondents' constitutional claims even acknowledged. Thus, by ignoring Respondents' complaint, the Petition avoids grappling with the issue of denial of any forum whatsoever to address substantial constitutional issues.

Finally, the government's petition ignores the impact of the U. S. Court of Appeals' reversal of the lower court's decision to the extent it mandated a particular relief. Rather, the U. S. Court of Appeals simply remanded the case to the Secretary for reconsideration of the Michigan reimbursement plan under Part B of the Medicare Program with instructions to consider such statutory mandate that fee ceilings be based upon similar services. 728 F. 2d at 333. Rather than appeal on the merits, the government has seen fit to establish one fee ceiling for all physicians. See Attachment B. Furthermore, the suggestion that Petitioners continue to contest the decision of this case on the merits is in direct contravention of the testimony established in this case, that there was no meaningful difference between physicians of different specialties performing the same medical procedure.

SUMMARY OF ARGUMENT

This case presents the issue of whether the Department of Health and Human Services can develop a system of hearings and review that effectively preclude any possibility for the redress of substantial statutory and constitutional claims. The import of this Court's decisions in *Weinberger* v *Salfi*, 422 US 749 (1975); *United States* v *Erika, Inc.*, 456 US 201 (1982); *Heckler* v *Ringer*, ___ *US* ___; *104 S Ct 2013 (1984); and Schweiker* v *McClure*, 456 US 188 (1982) strongly indicate that the interpretation placed upon 42 USC Sec. 405(h) and Sec. 1395ff by the Petitioner is untenable.

The regulatory and administrative authority pertinent to this matter strip the administrative process of the ability to address the claims pressed by Respondents. The decisions of this Court have never concluded that the above statutory provisions preclude jurisdiction over substantial statutory or constitutional claims for which no other review is accorded. Rather, this court has in fact addressed substantial constitutional claims arising out of the Medicare Program in *Schweiker* v *McClure, supra*. This Court's decisions in *Salfi, Erika*, and *Ringer* stand for the proposition that claimants must pursue any available administrative remedy before asserting federal court jurisdiction and that federal court jurisdiction is precluded for "amount of benefit" cases.

This case cannot be characterized as an "amount of benefit" case which involves whether a particular claim is payable under the Medicare Program or the specific amount of payment. To the contrary, Respondents have never sought an increase in the level of payments or a specific amount of payment. Rather, Respondents, as in *McClure*, made a broad statutory and constitutional claim against the federal regulations. The claims made did not address the specific amount to be paid, but rather addressed a classification scheme inconsistent with a mandate of the Medicare statute. These claims were certainly not insubstantial.

The construction of Sec. 405(h) and 1395ff advanced by Petitioners would allow Petitioners to violate the applicable

statute and the United States Constitution with impunity. Indeed, in the district court Petitioners admitted a violation of the law, refused the district court's suggestion that a remedy be fashioned, but yet now insist that no forum exists for redress of the very violation they concede. It is respectfully suggested that this Court must interpret 42 USC Sec. 405(h) and 1395ff in such a fashion as to avoid a serious constitutional issue and in a fashion which also gives meaning and effect to the various provisions of the Act.

ARGUMENT

Through the last several years, this Court has had several occasions to consider the administrative review mechanisms of the Social Security Act and the related issue of federal court jurisdiction. See *Weinberger* v *Salfi*, 422 U.S. 749 (1975); *United States* v *Erika, Inc.*, 456 U.S. 201 (1982); *Heckler* v *Ringer*, ___ US ___; 104 S. Ct. 2013 (1984). In addition, this court has previously addressed, without any significant discussion of jurisdiction, a constitutional challenge to the administrative review mechanisms of Part B of the Medicare Program. *Schweiker* v *McClure*, 456 U.S. 188 (1982). Contrary to the Petitioners' suggestion, a review of these decisions indicates that this Court has never interpreted or applied the provisions of the Social Security Act as foreclosing all forums to redress substantial statutory or constitutional issues.

In *Weinberger* v *Salfi*, *supra* at 761, this Court faced a constitutional challenge to provisions of the Social Security Act and carefully reviewed each of the three sections contained within Sec. 405(h) and concluded that this section constitutes more than a requirement for exhaustion of administrative remedies. The court further rejected any narrow reading of the language "any claim arising under . . . the Social Security Act" since the statute provided "both the standing and substantive basis for the presentation of . . . constitutional contentions." Significant

in the *Salfi* decision is the distinction of the prior case of *Johnson* v *Robison*, 415 U.S. 361 (1974), the court noting that acceptance of the government's interpretation of the statute in *Robison* would have meant that no judicial consideration of a constitutional challenge could have taken place. The court stated:

> Not only would such a restriction have been extraordinary, such that 'clear and convincing' evidence would be required before we could ascribe such intent to Congress . . . but it would have raised a serious constitutional question of the validity of the statute so construed. 422 U.S. at 763 (citations omitted)

It is clear from reviewing the decision in *Salfi* that this Court was concerned that Sec. 405(h) not be interpreted to preclude constitutional challenges. This principle was neither ignored nor forgotten in the subsequent decisions of this Court.

In *United States* v *Erika*, *supra*, the court faced a review following administrative hearing by the carrier pursuant to 42 USC Sec. 1395u(b)(3). The substantive challenge boiled down to the carrier's determination to base the reasonable charge calculation and payment to *Erika* upon a price list utilized by the Respondent. There was no constitutional claim pressed. See *US* v *Erika*, *supra* at fn. 5.

This court's opinion in *Erika* dealt mainly with the correct interpretation to be given to Sec. 405(h) in conjunction with Sec. 1395ff. Because Sec. 1395ff failed to provide for a hearing by the Secretary (or judicial review thereafter) for "amount of benefit" cases under Part B, and because the legislative history revealed an intent to preclude federal court jurisdiction in such cases, the court determined that the administrative hearing afforded in *Erika* was appropriate and no further judicial review was permissible.

Contemporaneously with issuing the *Erika* opinion, this Court also handed down its opinion in *Schweiker* v

McClure, supra. The *McClure* case once again dealt with Part B of the Medicare Program but was distinct from *Erika* in that the challenge in *McClure* was directed at the hearing procedure mandated by 42 USC Sec. 1395u(b)(3) and implemented through regulation. The Court did not consider the basic jurisdictional issue, but went on to substantively address the constitutional claims and ruled that the carrier hearing, as mandated by the statute and implemented through regulations, passed constitutional muster.

Heckler v *Ringer, supra*, again focused upon judicial review of a Medicare case, although the decision was limited, in the main, to a discussion of judicial review of a Part A claim. *Heckler* v *Ringer, supra*, at n. 4. Respondents challenged an instruction by the Secretary which denied Medicare reimbursement for a particular surgical procedure. The precise issue faced by this Court was whether the Respondents could pursue their case in federal district court prior to their claims first channeled into the administrative process available under Part A and, in the case of claimant Ringer, before the surgery was actually performed.

In *Ringer*, this Court declined the invitation not to enforce the provisions of Sec. 405(h) to a Medicare claimant since to do otherwise would have opened the door and allowed a by-pass of the administrative remedy and judicial review provided by the act. This court noted:

> If we allow claimants in Ringer's position to challenge in federal court the Secretary's determination . . . that BCBR surgery is not a covered service, we would be inviting them to by-pass the exhaustion requirements of the Medicare Act by simply bringing declaratory judgment actions in federal court before they undergo the medical procedure in question. *Ringer, supra*, at 2025.

From these precedents, the Petitioners weave their argument for requesting relief from this Court. From the *Salfi* opinion they take the principle that Sec. 405(h) applies to any action "arising under" the Medicare Act. From the

Erika opinion they take the principle that all "amount of benefit" cases are barred from judicial review (broadening this concept to any challenge "affecting the amount of benefits", see Questions Presented in Petition and Statement of Case in Petition).

From the *Ringer* opinion, Petitioners take the principle that administrative channels and judicial review established by Sec. 405(g) and Sec. 405(h) cannot be circumvented by a premature district court action by clothing benefit cases in procedural dress. Petitioners then characterize the present case as "affecting the amount of benefits" which "arises under" the Medicare statute and hence without federal court jurisdiction pursuant to Sec. 405(h). Despite the Petitioners' best efforts these cases cannot establish the principle that judicial review is foreclosed in a Part B Medicare case in which a statutory and constitutional challenge is made and for which there is no administrative process to address these challenges. Indeed, the decisions of this Court stand for quite the opposite.

The court's analysis of *Salfi* recognizes that the challenges made by the claimants could be properly addressed and channeled through the administrative process provided by Sec. 405(g). In *Erika* judicial review was foreclosed but only over certain types of challenges, namely amount of benefit cases, since there was clear legislative intent to free the judicial process of these small benefit cases. This Court recognized that the constitutional claims presented were neither pressed before this court nor of a substantial nature. In *Erika* a judicial forum was not available since such a forum was not expressly provided by statute and legislative history revealed an intent to bar judicial review of the very type of claim being pressed. Petitioners' attempt to broaden the holding in *Erika* to any case "affecting the amount of benefits" is in substantial contrast to the legislative history this Court relied upon in support of its decision that there was no federal court jurisdiction in amount of benefit cases. In that case, the Court quoted the Senate report on the original

Medicare Act, which stated that the Act did not provide for judicial review of "a determination concerning the amount of benefits under Part B" and that the provision for review by carriers under Part B was intended as the "exclusive" remedy. See *Erika*, *supra* at 208, 209. Quoting S. Rep. 404, 89 Cong. 1st Sess. 44-45 (1965). The court also noted the conference report on the 1972 Amendments, 42 USC 1395ff, which explained that "there is no authorization . . . for judicial review on matters *solely* involving amount of benefits under Part B" (456 US at 210, quoting H. R. Conf. Rep. 92-1605, 92nd Cong. 2d Sess. 51 (1972). (Emphasis added.)

The present case was initiated as a statutory and constitutional challenge to regulation promulgated by the Secretary. Respondents were not seeking any specific payment level concerning a particular medical service (contrast both *Erika* and *Ringer*) but were claiming that the Secretary and the Carrier had gone beyond the basic mandate of both the Medicare Act and the United States Constitution. Like *McClure*, Respondents made a broad challenge to the promulgation of a regulation. That challenge was not based upon a question of medical necessity or proper application of the Medicare regulations to a particular claim for payment. Unlike the challenge asserted by Respondents, such claims could have been pursued through the administrative hearing mechanism mandated by 42 USC 1395u(b)(3) and established by regulation.

Respondents' claims were based on the premise that whatever payments are to be made should be made according to "similar service" and the regulation in issue violated this statutory requirement. Respondents objected not to the application of the classification scheme set forth in the regulation, but rather the classification scheme itself. In an attempt to equate Respondents' claim to that of the Respondents in *Erika*, the Petitioners makes note of the fact that the Court of Appeals acknowledged that the eventual result of this suit may cause an increase in amounts of reimbursement for services to family physicians. See Petition at p. 6.

The actual quote from the Court of Appeals provides a much more thorough and accurate analysis:

> In this case BC/BSM contends this suit involves simply a dispute over the amount of reimbursement due. In a word, BC/BSM contends, Michigan Academy is simply seeking to have family physicians and their patients moved to the more lucrative specialty screen, boiling down to an argument for an increase in amounts reimbursed. *Erika*, it concludes, should bar this suit outright. This argument, however, is without merit.
>
> While the eventual result of this suit may cause an increase in amounts of reimbursement, that does not necessarily follow. In some cases the result may be an increased amount of reimbursement, and in others, a reduction in reimbursement could occur. Michigan Academy, at bottom line, is challenging the overall mechanism for determining the amounts of reimbursements, not the actual value of any particular reimbursement.
> 728 F. 2d at 330.

Accordingly, it is inaccurate to characterize Respondents' case as simply seeking to increase the "amount of benefits" they may receive under the Medicare Program. The reasonable charge calculation under the Medicare Program requires a grouping of all similar services to establish a ceiling at that figure which would pay seventy-five percent of all claims submitted. See 42 USC Sec. 1395u(b)(3). Respondents sought the elimination of specialty screens, not the transfer of individual claims from the "generalist screen" to the "specialist screen." Such a remedy would be totally contrary to the crux of Respondents' claim that the maintenance of different screens among physicians for the same service violated the Medicare statute and the United States Constitution. Respondents' claims were delineated to address the groupings or classification scheme itself and the illegal and unconstitutional aspects of the disputed regula-

tion. Since the thrust of Respondents' Complaint related to those groupings, a payment dispute on an individual claim could not afford the relief requested. Rather, the overall grouping mechanism had to be reviewed in the context of Petitioners' statutory authority for its actions.

Perhaps nothing belies the Petitioners' attempt to pigeon-hole Respondents' challenges as "amount of benefits claims" more clearly than Petitioners' own implementation of 42 USC 1395u(b)(3), the statutory authority for carrier hearings on amount of benefit cases. As noted, Petitioners specifically removed from the carrier's power the authority to address the very type of challenge being pursued by Respondents. Undaunted, Respondents now attempt to pigeon-hole Respondents' challenges as "amount of benefit" claims while denying a forum for review.

A review of the statutory and regulatory scheme here certainly does not reveal "a fairly discernible intent" to preclude judicial review for a Part B case which raises substantial statutory and constitutional issues. The impact of Sec. 1395ff in conjunction with Sec. 1395u(b)(3) and Sec. 405(h) evidences a legislative intent to channel small amount of benefit cases through an administrative hearing process conducted not by the Secretary but by the carrier.

What is discernible in this scheme is only the foreclosure of judicial review of those issues for which an administrative hearing is available. The legislative history discussed in *Erika* obviously cannot be read as evidencing an intent to foreclose judicial review for claims of a type other than the amount of benefit claims discussed in that history.

In fact, the essence of the Petitioner's legal posture is that an agency of the federal government may violate the Medicare statute or the Fifth Amendment of the United States Constitution with no forum for those affected to take redress. The complete absence of judicial oversight over the entire regulatory program would raise a serious constitu-

tional issue concerning the improper delegation of legislative power to the executive. See *Amalgamated Meat Cutters* v *Connally*, 337 F. Supp. 737, 759 (DCDC 1971) and *Yakus* v *United States*, 331 U.S. 414, 423-426 (1944). The denial of a forum for addressing constitutional rights is a question of exceptional importance and significance, and is tantamount to overruling *Marbury* v *Madison*, 1 Cranch 137, 2 L. Ed. 60 (1803). It is a matter of law and precedent with this Court that the foreclosure of all forums to address substantial constitutional claims itself raises "serious constitutional questions." See *Johnson* v *Robison*, *supra*, and *Bob Jones University* v *Simons*, 416 U.S. 725 (1974). This Court has called it a "cardinal principle" that statutory provisions are to be interpreted so as to avoid this very sort of basic constitutional question. See *United States* v *Thirty Seven (37) Photographs*, 402 U.S. 363 (1971); *Johnson* v *Robison*, *supra*, and *Crowell* v *Benson*, 285 U.S. 22 (1932).

The Petitioners characterize the Sixth Circuit's decision as a disregard of this Court's clear pronouncement and perhaps encouraging anarchy. See Petition, pp. 11, 22. One would at least expect that such strong language be accompanied with a clear statement of Petitioners' position. Unfortunately, the Petitioners have thoroughly ignored the basic fact that a denial of federal court jurisdiction in this case would preclude any forum to address the statutory and constitutional challenges of Respondents and would create an extraordinary constitutional issue in itself. Petitioners simply have not demonstrated a basis for granting of this Writ of Certiorari.

CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

FRIMET, BELLAMY & GILCHRIST, P.C.
By: ALAN G. GILCHRIST
Counsel of Record

ATTACHMENT A

TRIAL TRANSCRIPT

* * * trial.

Q. Have you ever heard of any rationale with then HHS as to why the carrier in Michigan has treated board eligible family physicians different from other types of board eligible physicians?

A. I have never seen anything that fully explains that. I have been under the impression at one time or another that there were differences in the various board rules dealing with the requirements of becoming board certified that the carrier was concerned about, but I do not recall what they are specifically.

MS. MAYES: Your Honor, if I might just raise a question. We have indicated at the beginning of this case that we believe that we were incorrect in defining family practioners, that is, those who were board eligible, as not being specialists, and that therefore we conceded that fact before this trial ever began. That was an incorrect application of that board eligible definition, so that board eligible family practioners should be defined as specialists by the carrier in the State of Michigan.

THE COURT: And should be put in the screen?

MS. MAYES: That question is what is left open, but the definition of what we called them was (64) incorrect.

THE COURT: All right. Go ahead.

BY MR. GILCHRIST:

Q. Would it be a fair statement that the rationale that you have heard for treating board eligible family physicians differently from other board eligible physicians has never been related to any charging patterns?

A. I am not sure I understand your question. I am sorry.

Q. Well, you said you talked about—there was something about qualifications of speciality boards as one of the rationale.

ATTACHMENT B

[LETTERHEAD OF BLUE CROSS/BLUE SHIELD]

August 27, 1984

C. Edward Cotton, M.D.
President
Michigan Academy of Family Physicians
109 East Oakland
Lansing, Michigan 48906

Dear Doctor Cotton:

Attached for your information is an announcement on BCBSM Regular Business/Medicare comparability. As a result of instructions from the Health Care Financing Administration (HCFA), BCBSM will apply corresponding Regular Business screens as comparability limits on Medicare prevailing screens. The attached explains the details of the HCFA directive.

Although this information will appear in a future Record article, I wanted to share this with you as soon as possible.

Sincerely,

(s) Robert H. Hamburg, M.D.
Senior Liaison Consultant
Medical Affairs

RHH:svc
Attachment

REGULAR BUSINESS PROGRAM SCREEN COMPARABILITY AND COURT DECISION APPLY TO MEDICARE SCREEN FREEZE

The Deficit Reduction Act of 1984 (DRA 1984) has put a freeze on physician payment levels from July 1, 1984 through September 30, 1985, or 15 months. At the same time, the Health Care Financing Administration (HCFA) has instructed BCBSM that Comparability (Section 1842(b)(3) of the Medicare law) applies to the frozen screen levels. For regulations concerning Comparability, see Section 42 CFR 405.508. Therefore, BCBSM will apply the corresponding regular business screens as Comparability limits on Medicare prevailing screens.

The regular business screens were established based on a relative value scale. A relative value scale ranks procedures by comparison of the complexity, skill, time and resources required for each procedure. Procedures that are more complex and/or require more skill, time or resources are ranked higher than those that require less. In the past, regular business screens were determined primarily based on charges billed to BCBSM. Because charges do not always reflect complexity, skill, time and resources of one procedure in relation to another; screens for many procedures were too low, while screens for other procedures were too high. To correct the imbalance, the relative value relationship methodology for establishment of maximum screens was approved by the BCBSM Board of Directors in 1983, and is currently used for regular business screen determination.

In addition, BCBSM was instructed by HCFA to implement a decision handed down by the United States Court of Appeals for the Sixth Circuit. The court decision requires BCBSM to merge charge data for all physicians, including chiropractors, dentists, podiatrists, and optometrists in calculating a new prevailing charge screen. BCBSM will apply this calculation to the frozen fee screens. As a result, physicians may experience changes in payment for selected services.